August 16, 2019

FROM: Bryon E. "BJ" Coleman Jr. CEO, North Tampa Behavioral Hospital
TO: Neil Beedi, Investigative Reporter, Tampa Bay Times
Subject: North Tampa Behavioral Hospital Response to August 8th Email & Questions

Dear Neil,
Thank you for reaching out with questions regarding your planned story and affording North Tampa Behavioral Hospital (NTBH) the opportunity to respond to your inquiries with important facts and context about our facility, the patients we are honored to treat and the overall realities, complexities and challenges of behavioral health care delivery and hospital regulatory compliance processes in Florida and across the U.S.

As I mentioned at the outset of our email correspondence, state and federal patient privacy laws and our own internal Code of Ethics significantly impedes our ability to offer detailed comment on any specific patient encounter, clinical treatment decision or alleged incident that could risk disclosing confidential and protected patient information. While journalists and the patients themselves are not held to this same standard, please understand that in many instances we are nonetheless prohibited from responding even in cases where the information or allegations are factually untrue, misleading or incomplete.

Based on your limited number of questions and somewhat cryptic allegations (many inaccurate) it appears your planned story angle and reporting style of highlighting and extrapolating a very small number of non-representative incidents occurring over many years has the potential to provide an incomplete and distorted portrayal of inpatient psychiatric treatment in general and NTBH in particular. It is our hope that the below information will provide an important perspective that will be objectively incorporated into your story.

About NTBH: History, Leadership, Clinical Quality & Strong Patient Satisfaction:

Established in 2013, NTBH provides specialized, compassionate and evidence-based inpatient and intensive outpatient behavioral health and substance use treatment services to patients living with serious and complex conditions including major depression, anxiety, bipolar, Post-Traumatic Stress Disorder (PTSD), suicidal ideation, schizophrenia, psychosis, chemical dependency/addiction and other, often co-existing conditions requiring a comprehensive individualized approach to care. Since our founding, NTBH and its dedicated clinicians and support staff have provided high-quality care (both BH and substance use) to nearly 17,000 patients encompassing 125,000+ total treatment days, and over 20,000 visits to our various outpatient treatment programs.

Many of our patients arrive at NTBH experiencing some of the most profoundly challenging periods of their lives, including being transferred (and in some cases turned away) from other hospitals that are unable or unwilling to provide the specialized services offered at our hospital. NTBH diverse patient population includes individuals from many socioeconomic backgrounds and stages of life (e.g. young adult, adult, geriatric) with specialized programs for specific patient groups such as military members and veterans.

At all times since its founding, NTBH has been fully licensed and certified as a provider in good standing with all state and federal regulatory and licensing authorities, including the FL Agency For Health Care Administration (AHCA), FL Department of Children and Families (DCF), U.S Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS) and TriCare (DoD's insurer). NTBH is accredited by The Joint Commission (TJC), an independent non-profit organization with a 60-year record of conducting robust accreditation and inspection services on behalf of the federal government.

Notwithstanding the large number of severe acuity (severity) patients treated over the past 6.5 years, NTBH's rate of serious and severe level incidents is very low, comprising just 0.000597% of total patient treatment days. Nevertheless, all NTBH clinicians, support staff and administrators understand that we have a solemn duty and moral responsibility to our patients and their loved ones to provide the highest-level care possible while constantly endeavoring to improve and innovate across all aspects of our operations.

To this end, we view patient satisfaction surveys as an important indicator and benchmark of quality. Over the past 13 months based on the anonymous survey responses of over 600 patients, nearly 74% rated their overall satisfaction as Very Good or Good. Attached as part of the materials is a summary report from our survey vendor PressGaney detailed these and similarly positive findings.

NTBH endeavors to recruit and employ dedicated, experienced and compassionate physicians, nurses, and clinical support staff specifically trained to work with our specialized and complex patient population. For example, our Chief Nursing Officer has nearly 20 years-experience encompassing direct nursing, clinical administration, quality assurance, compliance and patient experience roles at many respected behavioral, acute/medical surgical hospitals and BH focused home health organizations in the greater Tampa area. She has overseen large scale patient safety best practices initiatives, coordinated crisis intervention trainings for local law enforcement officers and authored hospital wide employee training materials. She holds three degrees including Bachelors in both Nursing and Psychology and MBA. She is also a licensed Healthcare Risk Manager. Similarly, our Chief Medical Officer has practiced medicine in both the U.S. and abroad for over 15 years, the last 8 as an American Board of Psychiatry and Neurology certified Psychiatrist at multiple inpatient and intensive outpatient treatment settings in Florida, Indiana and Mississippi. He received an Outstanding Resident Award from the Jackson, MS VA Medical Center in 2009.

I'd also wish to address your inquiries regarding my educational and professional experience within the context of the overall healthcare sector and my current role as NTBH CEO. As you are likely aware, the ranks of healthcare and hospital administrators include individuals with very diverse educational and professional experiences, perspectives and skill sets. While some healthcare facility leaders transition from clinical roles, many others (including myself) bring expertise and transferrable skills from previous experiences in management and team leadership, accounting and budgeting, operations and logistics, marketing and business development, law and other relevant vocations and proficiencies which comprise essential elements of a successful hospital CEO.

Prior to joining NTBH, I served as the Vice President of Sales at large regional transportation logistics company, overseeing business development programs and client retention initiatives for portfolios totaling $32+million in annual review. I also served as an Employee Benefit Consultant (including for complex health insurance products) at a major national bank where I was responsible for cultivating and growing relationships with customers though proactive community outreach and engagement while also serving as the primary liaison and account manager for many large and complex client portfolios. These experiences required a consistent focus on relationship building and customer satisfaction, strategic planning, logistics, budgeting and financial forecasting which are all core elements of my role at NTBH. As it relates to my prior career as a professional (NFL, CFL and Arena League) football quarterback, I would similarly maintain that that there are many valuable, transferrable skills and attributes including team leadership, situational analysis and sound decision-making under extreme time pressure, compliance with detailed and evolving rules multi-tasking and ability to course correct without sacrificing quality.

For your reference, as part of the overall written materials, I have included a digest summarizing hospital CEO role expectations and governing body standards from CMS, The Joint Commission and AHCA. As you will see, the core competencies are primarily focused on team management, budgeting, operational and compliance matters, with the Chief Medical Officer and Chief Nursing Officer leading clinical functions.

Clinical Admission Criteria, FL "Baker Act" Protocols & Length of Stay Determinations:

Three main criteria are assessed for any admission to a psychiatric facility such as NTBH satisfaction of one or more which will justify admission, whether voluntary or involuntary. The first is suicidality – if someone is suicidal, or at significant risk of harm to themselves. The second is whether there is a significant risk that the patient may harm someone else, which is often referred to as homicidality. The third is whether the individual is gravely disabled and/or unable to care for themselves to the extent that their present psychiatric symptoms and diagnosis significantly interferes with their ability to undertake essential daily activities. These admission criteria are uniform across all acute psychiatric facilities including NTBH and the clinical determination on whether to admit any patient is made by the attending psychiatrist in consultation with other members of the clinical support team and is based on the patient's unique symptoms and current functioning.

Similarly, each state proscribes specific legal protocols for involuntarily committing an individual into inpatient care if he or she is determined (based on the opinion of one or more applicable experts) to constitute a legitimate risk to themselves or the overall community. The Florida Mental Health Act of 1971 (FL Statute 394.451-394.47891 (2009 rev.), commonly known as the "Baker Act," permits the involuntary examination and temporary commitment of individuals who meet certain established clinical and legal criteria. NTBH is one of the few local facilities designated as a Baker Act receiving facility given our unique clinical expertise in providing high quality care to some of the most complex and challenging BH patients and conditions. It is important to note that the initial determinations and attestations that a particular patient requires involuntary care is typically not made by NTBH or any of its clinicians, but rather by the initial treating facility (typically acute/medical emergency) or by other authorized parties such as law enforcement or EMS who transport the patient to our facility.

Nevertheless, all patients (including those initially admitted with Baker Act/involuntary status) patients are provided a full evaluation by the attending psychiatrist regarding suitability for both admission and involuntary status designation including where deemed clinically appropriate and safe for the patient; the option to re-classify as a voluntary patient. In situations where the psychiatrist and other clinical staff determine that a patient for their own safety and the safety of the community requires ongoing involuntary treatment, NTBH clinicians (like all "Baker Act" credentialed facilities) are required to outline such concerns within a formal petition that must signed off by two psychiatrists and approved by an impartial judge. A facility itself cannot commit or "Baker Act" a patient on its own; only qualified clinical personnel can do so, through established legal and clinical protocols.

Importantly, NTBH does not actively advertise or market its status as a credentialed Baker Act receiving facility. The fact that we treat a significant number of such patients is instead related to increased community demand and relatively few facilities that are qualified to provide the specialized care as well as the reputation of our clinicians among referring hospitals and community partners such as law enforcement. Over the past 6 years, patients admitted under initial involuntary status have on average comprised approximately 65% of NTBH's total census at the time of admission. Many of these patients eventually are transitioned to voluntary status based on determinations in accordance with the statute and clinical best practices.

Regarding your questions and inferences about purported patient allegations relating to length of stay (LOS) and potential financial impacts in comparison to other hospital facilities, some important corrections, clarifications and context are necessary to set the record straight. Regardless of a patient's voluntary or involuntary status, all decisions regarding admission, treatment and discharge including LOS are clinical determinations made by the attending psychiatrist in full consultation with other members of the treatment team based on that patient's unique condition acuity. Key factors include the patient's acuity (illness severity and functioning), treatment progression, feasibility of post discharge treatment options and similar considerations. Every patient care decision is made with the goal of furthering the best interests of our patients; this includes decisions regarding the amount of time a patient spends in treatment.

You also erroneously imply that NTBH personnel could keep a patient (including involuntary patients) hospitalized solely for financial considerations, that NTBH's average length of stay (ALOS) and its profit margins are demonstrably higher than that of its peers. These inferences are highly inaccurate, misleading and unsupported by publicly available data, including AHCA's aggregate hospital financial and ALOS data. First, as stated above, all decisions regarding patient length of stay are made independently by the attending physician with input of the clinical treatment team based on patient progress toward treatment goals. Second, in most states including Florida, initial and continuing stay clinical decisions are often made in consultation with state and private insurance utilization management representatives, outside case managers, and in the case of involuntary patients, independent judges, who review extensive clinical materials and speak often with treatment providers before rendering pre-authorization decisions. NTBH therefore rejects any accusation that patients not meeting clinical criteria are intentionally held for purely financial reasons and no regulatory or accreditation survey has ever alleged or revealed any such conduct.

Third, mental health facilities and the patients we treat are unique, complex and often unlike traditional acute care hospitals or patients. In light of the serious nature of their conditions, many patients (including many admitted under "Baker Act" protocols) are often unable to make similar types of objective judgements regarding the necessity of clinical care and suitability of admission and discharge that they ordinarily would when undergoing other non-psychiatric treatment. These situation can invariably lead to confrontations and disagreements where a particular patient believes they don't need care when the totality of the clinical evidence confirms the necessity of such care. There are also scenarios where evaluation, discharge planning and document and recording may be slightly delayed due to scheduling, documentation sign-off and other factors that have nothing to do with financial considerations and are typically resolved within a very short period. Fourth, a subjective examination of both publicly available audited hospital financial statements and NTBH's own financial and patient stay records do not support your contention that our aggregate profit margins or ALOS are appreciably higher than other Florida psychiatric facilities.

Attached to this email is a spreadsheet detailing NTBH's aggregate operational and financial data from 2013 – 2019 YTD, including information we previously submitted to the state in accordance with our reporting obligations. We have also included aggregate annual published data from AHCA's online Financial Dashboard data which includes information from our founding though 2017. As you can clearly see, while ALOS and profit margin vary over the years based on a variety of factors, NTBH's average annual figures for both the 2013-2017 (i.e. based on currently published data) and 2013 - YTD 2019 are slightly lower than the multi-year averages of other Florida psychiatric hospitals.

Finally, the contention that involuntary patients comprise an unusually "lucrative" segment is also inaccurate. In general, involuntarily committed patients include a higher percentage of indigent and charity care situations compared to voluntary patients with either commercial insurance (which generally reimburses at higher rate than Medicaid) or those who elect to self-pay. Since its founding, NTBH has provided millions of dollars of uncompensated and charity care to patients, including those arriving at our facility under a Baker Act petitions.

Isolated Regulatory Compliance & Adverse Incident Allegations in Context:

You make reference to certain regulatory compliance, law enforcement and other isolated matters occurring over many years. These characterizations provide a highly incomplete and distorted depiction of the overall realities of BH care, the comprehensive regulatory oversight system governing it and NTBH's aggregate positive record of compliance, low serious incident rates, clinical quality assurance and risk management programs.

As stated above, NTBH is fully licensed, certified and in good standing with all relevant state and federal government regulatory agencies and insurance providers (Medicare, Medicaid, TriCare and commercial providers). NTBH has never been suspended or terminated by any government or commercial insurer nor has it ever been subjected to fines or licensure actions (including revocations) or restrictions of any kind. NTBH is also fully accredited by The Joint Commission (TJC), a non-profit organization with a 60-year record of conducting comprehensive accreditation services on behalf of the federal government. TJC performs intrusive onsite triennial onsite accreditation inspections as well as unannounced visits.

Like all U.S. healthcare facilities, NTBH is routinely subject to unannounced visits and detailed inspections ("surveys") by federal and state licensing agencies and regulators (in FL AHCA, DCF) as well as independent accreditation organizations such as The Joint Commission with authorized deeming authority from CMS. Regulators and accreditors conduct thousands of inspections annually at hospital facilities nationwide. Incident and deficiency reports, corresponding Plans of Correction (POC), occasional notices of potential termination of CMS certification or similar state enforcement actions represent routine aspects of the comprehensive regulatory process governing all hospital facilities. The surveys, depending on the circumstances, can be triggered the regulator itself, or in other instances from complaints (whether substantiated or not) from patients, staff and family members as well as the facility self-reporting incidents requiring an onsite survey inspection.

These site visits include but are not limited to, reviewing current and historic performance data, medical records reviews, facility inspections, patient interviews, employee interviews, staffing sufficiency, and a host of other clinical and environment of care concerns. Regulators and accreditors can and do make unannounced visits with or without cause at any time of their choosing. The central goal of the regulatory process is to ensure that all facilities are compliant with CMS and state licensing regulations and accreditation standards while providing appropriate, therapeutic care to patients. Thousands of facilities nationwide encounter instances of alleged non-compliance in clinical and operational areas sometimes necessitating follow up surveys, CMS termination threats and other more serious remedial and punitive enforcement measures.

If a facility is suspected to be non-compliant in a specific area, CMS and many state regulatory authorities and accreditation organizations utilizes multi-tier system to indicate the alleged severity of the non-compliance. Standard-level findings constitute issues a facility must address but which do not jeopardize its participation in federal healthcare programs, usually minor administrative, maintenance or record keeping matters. Conditional-level deficiencies are more serious allegations that require a facility to submit a formal POC to the applicable regulator. subcategory of the conditional level is the immediate jeopardy designation. These scenarios stem from findings deemed serious enough that regulators can suspend admissions, impose fines, freeze reimbursements and, in rare instances, terminate a facility as a provider and force it to temporarily or permanently close and transfer patients. Alleged patient safety-related or other citations do not necessarily equate to a definitive conclusion that any actual patient harm occurred or will occur. Rather, it constitutes a subjective allegation or finding from a particular surveyor(s) that there is potential for harm.

The vast majority of survey and accreditation inspections (including CMS, AHCA/licensure, DCF, and The Joint Commission) conducted at NTBH over the past 6.5 years resulted in determinations that our hospital was in substantial compliance with all CMS Conditions of Participation (COP), TJC accreditation and FL licensure requirements with several surveys 100% deficiency free, which is our consistent goal. **NTBH has never been subjected to any immediate jeopardy designations, fines, admission freezes, payment suspensions or facility closure orders by any regulator or accreditor.**

Notwithstanding, NTBH takes all feedback received from regulators and accreditors seriously and views these important processes as key opportunities to consistently explore ways we can improve on the already high quality the services we provide. Similar to nearly

every hospital (whether or acute or BH), a number of surveys conducted by regulators and accreditation organizations since NTBH's founding included alleged citations. Many related to standard and administrative matters not directly impacting patient care or safety and which were quickly resolved without the need for a formal POC. Other (mostly AHCA surveys) included more serious alleged shortcomings requiring submission and approval of a POC. In each of these relatively rare cases, NTBH full addressed and remediated all concerns to the full satisfaction of AHCA. The preparation and submission of POCs (even in cases when we may disagree with the merits of the allegation) are designed to reduce the possibility of the potential or actual harm from occurring or re-occurring, the goals of which NTBH strongly and consistently supports.

You also briefly reference in somewhat vague terms alleged incidents (purportedly extrapolated from police reports and surveys), claiming that NTBH "has allowed patients to hurt themselves or others." This representation is also incorrect and misleading as we would never knowingly or willfully "allow" or permit any patient to hurt themselves or others. The safety of all of our patients and staff members is of tantamount importance and a responsibility we take very seriously, particularly in light of the high acuity patient population that can occasionally exhibit aggressive and unpredictable behaviors. As stated earlier, severe and grave incidents (e.g. assaults, disturbances, patient and/or staff injuries, elopements, etc.) are highly uncommon occurrences at NTBH, with such matters comprising 0.000597% of all patient treatment days since 2013.

Similarly, law enforcement dispatch to NTBH (particularly for 9-11 calls) is not a common practice or occurrence. This is in large part due to our staff's specialized training (including in advanced de-escalation and therapeutic restraint techniques) which better equips them to deal with the unique medical needs of psychiatric patients as opposed to police who are primarily trained in legal enforcement and public safety issues. However, like nearly all hospitals (particularly ones treating patients whose illnesses can manifest in aggressive and assaultive episodes), we do sporadically experience situations necessitating law enforcement support. Furthermore, state and federal law and regulations actually require notification and referral to law enforcement for particular types of matters including alleged abuse, serious property damage, theft and to serve outstanding warrants. Given that NTBH is a credentialed Baker Act receiving facility, police often transport needy patients to our hospital. Overall, NTBH values its long-standing collaborative relationship with all local law enforcement agencies and greatly appreciates their service to the community.

Notwithstanding our very low serious incident rates, NTBH constantly evaluates our policies (e.g. though ongoing staff training in advance de-escalation techniques), treatment protocols and capital improvement plans (including in safety/security technologies) in an effort to reduce negative incidents with the aspirational goal of zero negative incidents, including assaults and injuries to patients and staff. As part of this effort, NTBH maintains and adheres to strict policies requiring that all applicable adverse incidents be reported to AHCA and/or DCF in full accordance with FL statute 395.0197. Our staff are trained to identify events meeting criteria for reporting and our consistent goal and expectation is 100% compliance. It is also important to clarify that not all incidents (including ones that could reasonably be deemed undesirable) necessarily meet the formal legal criteria for classification as adverse based on the FL guidelines. It is NTBH policy to err on the side of disclosure of such incidents, both internally for evaluation and performance improvement purposes and to meet our state

reporting responsibilities. For the FL statute adverse incident requirements, NTBH's incident rate is 0.000199% of total patient treatment days between 2013 – 2019 YTD.

NTBH constantly strives for excellence in all aspects of our operations and because we hold ourselves to the highest clinical and ethical standards, we believe that even one negative incident or outcome is one too many. Nevertheless, we are mindful that over the course of treating thousands of patients annually, regrettable and unpredictable events will invariably occur including deviations from our hospital's own internal policies, procedures and high standards. We also forthrightly acknowledge that such events can result in negative and traumatic impacts to the individuals involved and to their loved ones. In these rare situations, we do our best to provide support and compassion to all those affected. It is also never our intention to diminish or trivialize the seriousness of these matters as they represent important opportunities for reflection, evaluation and improvement.

When these uncommon situations arise, we do our best to identify lessons learned and where applicable, make changes to our protocols while holding all individuals fully accountable for any actions which violate our policies and high expectations (including in the case of employees; mandatory retraining, suspensions and in serious cases, termination and potential referral to external regulators and law enforcement). We consistently strive to reduce and eliminate negative occurrences to all patients entrusted to our care as well as our valued staff members. We also strongly emphasize the crucial importance of placing such atypical events in the appropriate context i.e. as regrettable but wholly non-representative, temporary departures from the overall high level of quality clinical care experienced by the overwhelmingly majority of NTBH patients as opposed to evidence of any systemic problem.

Conclusion:

On behalf of the entire NTBH team, we sincerely hope this information will assist in your efforts to produce a balanced, fact-based portrayal of FL's mental health treatment system, our hospital's role in providing care to our valued patients and the dedicated efforts of our clinicians and support staff that I have the sincere privilege to lead.

Doing anything less would be unfortunate, just not for NTBH and similar providers but more importantly, in light of the ongoing and serious need to proactively confront the historical stigmas, shame and societal misconceptions that too often surround mental health disorders and patients. I'd therefore respectfully encourage you be sensitive and objective in how you portray these complex matters to lessen the possibility of the reportage being unwittingly misconstrued and sensationalized, perpetuating fear inducing stereotypes that could dissuade needy individuals from seeking life-saving care for themselves or their loved ones.

NTBH will continue to focus on our core mission of providing critically needed, high quality, compassionate and specialized care to our valued patients and their families across our beloved Tampa Bay community.

Sincerely,

Byron "BJ" Coleman Jr.
CEO, North Tampa Behavioral Health

North Tampa Behavioral Health		
Data Collection Request - Tampa Bay Times Inquiry		
	2013	2014
Admissions	158	2,010
Discharges	171	2,027
Patient Days	1,041	13,083
Self Pay %	35.0%	3.7%
OP Visits		2,321
Involuntary Admissions	N/A	701
% Involuntary	N/A	35%
Average Length of Stay (ALOS)	6.6	6.5
Audited Financial Statements (Submitted to AHCA)		
Net Revenue	208,074.00	8,207,067.00
Net Income	(1,677,100.00)	(1,282,176.00)
Operating Margin	-806.0%	-15.6%
SOURCE: AHCA Financial Data Dashboard Available at: https://www.floridahealthfinder.gov/researchers/studies-reports.aspx (Florida Hospital Financial Data) https://bi.ahca.myflorida.com		Statewide-Pyschiatric Hospitals
Average Operating Margin per AHCA		
For Profit	7%	10%
Not For Profit	7%	9%
		Statewide - Psychiatric Hospitals
Average Length of Stay (ALOS)	8.70	8.00

NTBH Charity Care 2017 - Present
NTBH Bad Debt 2017 - Present
% of Net Revenue

2015	**2016**	**2017**	**2018**	**2019-July YTD**
2,878	3,197	3,010	3,457	2,047
2,883	3,220	3,074	3,522	2,074
19,856	25,406	26,297	25,515	14,258
4.8%	4.0%	5.1%	6.9%	8.1%
5,894	3,871	3,274	3,469	1,449
1996	2307	2142	2383	1485
69%	72%	71%	69%	73%
6.9	7.9	8.7	7.4	7.0
13,670,333.00	17,455,021.00	18,271,320.00	17,349,207.00	**8,996,355.00**
1,645,292.00	2,642,409.00	2,546,698.00	954,192.00	**(411,910.00)**
12.0%	15.1%	13.9%	5.5%	**-4.6%**
10%	9%	9%	Not yet reported	Not Yet Reported
11%	10%	9%	Not yet reported	Not Yet Reported
7.70	7.60	7.00	Not yet reported	Not Yet Reported

$ 1,268,682.25	$ 765,352.00	$ 244,572.20
$ 1,107,649.23	$ 1,630,880.00	$ 1,434,376.00
6.9%	4.4%	2.7%

TOTALS & AVERAGES	
16,757	
16,971	
125,456	
9.7%	
20,278	
11,014	
65%	
7.3	
4.4%	
9%	
9%	
7.80	

*2013 excluded from average due to small patient census and first year operating loss status

INPATIENT BEHAV. HEALTH REPORT

Filter Definition

Filter	Choice(s)
Discharge Date	From 07/01/2018 To 08/15/2019

INPATIENT BEHAV. HEALTH REPORT

Question Analysis

Overall Section Question	Top Box	*n*
Overall	43.7	617
Admission	34.5	612
Speed of the admission process	16.4	608
Courtesy of staff during admission	44.8	603
Information about Patient's Rights	42.5	600
Unit	33.5	609
Comfort of the unit	26.4	606
Noise level of the unit	23.8	596
Overall condition of the unit	32.7	597
Cleanliness of your room †	43.8	603
Cleanliness of the unit †	40.9	594
Meals	37.4	607
Quality of the food	27.9	603
Quantity of the food	38.4	602
Temperature of the food	38.8	598
Cleanliness of the dining area †	44.6	594
Nursing	42.2	606
Friendliness/courtesy of the nurses	50.5	600
Nurses' intro to unit/program	38.6	594
Nurses' prompt response to requests	40.2	592
Nurses' info re treatment program	35.4	593
Nurses' info re medication	42.1	592
Helpfulness of the nurses	46.2	595
Psychiatrist	37.4	600
Courtesy of psychiatrist	42.7	599
Helpfulness of time w/psychiatrist	34.7	594
Psychiatrist's info re medication	37.3	584
Psychiatrist's info re condition	34.9	591
Treatment Team	54.0	598
Overall rating of social worker	50.9	574
Overall rating of case manager	52.2	579
Overall rating of rec therapist	57.3	576
Overall rating of psychiatric techs	55.5	586
Program Activities	41.7	598
Helpfulness of contact with staff	41.5	593
Time in therapeutic activities	37.2	591
Helpfulness group therapy	43.7	590
Helpfulness social/rec activities	44.3	589
Visitors & Family	46.4	428
Staff's courtesy toward visitors	49.5	410
Adequacy of visiting hours	37.7	414

Continued...

INPATIENT BEHAV. HEALTH REPORT

Question Analysis

Overall Section Question	Top Box	*n*
Confidentiality re visitors	49.9	405
Space to meet with family/friends	48.8	402
Discharge	55.9	599
Felt prepared for discharge	57.1	597
Understand disch med instructions	55.7	576
Info re care after discharge	55.8	579
Discharge instructions if need help	54.9	577
Personal Issues	47.1	578
Staff concern for privacy	48.1	574
Staff asked about physical pain	45.0	571
Physical pain taken care of	44.4	522
Safety felt on unit	48.7	569
Sensitive to lang/cultural needs	52.3	547
Sensitive to emotional needs	48.9	568
Sensitive to spiritual needs	47.4	542
Included in decisions re care	41.3	567
Staff concern to treat with respect †	51.7	572
Response to concerns/complaints †	42.7	562
Overall Assessment	46.3	578
Overall impression of the hospital	36.2	574
Feel condition has improved	48.6	570
Staff worked together care for you	47.2	574
Overall rating of care given	43.5	573
Likelihood of recommending	43.0	563
Overall cleanliness of hospital †	46.4	571
Kindness of staff †	52.2	571
Hopefulness as result of care †	53.6	569
Medical Doctor	44.3	560
Overall rating of medical doctor †	44.3	560

INPATIENT BEHAV. HEALTH REPORT

Frequency Analysis

n	Overall Section / Question	Very Poor %	Poor %	Fair %	Good %	Very Good %	Distribution
32,495	**Overall**	4.3%	5.3%	16.6%	30.1%	43.7%	
1,811	**Admission**	8.3%	9.9%	21.3%	26.1%	34.5%	
608	Speed of the admission process	16.8%	16.4%	29.6%	20.7%	16.4%	
603	Courtesy of staff during admission	2.7%	7.0%	15.9%	29.7%	44.8%	
600	Information about Patient's Rights	5.3%	6.2%	18.2%	27.8%	42.5%	
2,996	**Unit**	3.6%	6.9%	22.3%	33.6%	33.5%	
606	Comfort of the unit	5.3%	9.2%	25.1%	34.0%	26.4%	
596	Noise level of the unit	5.4%	10.6%	30.4%	29.9%	23.8%	
597	Overall condition of the unit	2.5%	4.9%	24.0%	36.0%	32.7%	
603	Cleanliness of your room †	2.5%	5.1%	15.6%	33.0%	43.8%	
594	Cleanliness of the unit †	2.5%	4.7%	16.7%	35.2%	40.9%	
2,397	**Meals**	3.8%	4.3%	19.6%	34.9%	37.4%	
603	Quality of the food	6.8%	6.6%	26.4%	32.3%	27.9%	
602	Quantity of the food	2.7%	4.8%	20.6%	33.6%	38.4%	
598	Temperature of the food	3.5%	2.8%	16.9%	38.0%	38.8%	
594	Cleanliness of the dining area †	2.0%	3.0%	14.6%	35.7%	44.6%	
3,566	**Nursing**	4.2%	7.1%	16.1%	30.4%	42.2%	
600	Friendliness/courtesy of the nurses	1.3%	3.2%	12.7%	32.3%	50.5%	
594	Nurses' intro to unit/program	4.2%	8.9%	16.0%	32.3%	38.6%	
592	Nurses' prompt response to requests	5.4%	7.1%	18.6%	28.7%	40.2%	
593	Nurses' info re treatment program	7.3%	10.1%	20.1%	27.2%	35.4%	
592	Nurses' info re medication	4.4%	7.9%	14.4%	31.3%	42.1%	
595	Helpfulness of the nurses	2.7%	5.4%	15.1%	30.6%	46.2%	
2,368	**Psychiatrist**	7.6%	7.4%	18.6%	29.0%	37.4%	
599	Courtesy of psychiatrist	5.5%	4.5%	16.5%	30.7%	42.7%	
594	Helpfulness of time w/psychiatrist	7.7%	8.6%	21.7%	27.3%	34.7%	
584	Psychiatrist's info re medication	8.0%	6.7%	17.1%	30.8%	37.3%	
591	Psychiatrist's info re condition	9.1%	9.8%	19.0%	27.2%	34.9%	
2,315	**Treatment Team**	2.4%	3.1%	12.9%	27.7%	54.0%	
574	Overall rating of social worker	2.6%	2.8%	13.8%	30.0%	50.9%	
579	Overall rating of case manager	2.9%	3.6%	13.6%	27.6%	52.2%	
576	Overall rating of rec therapist	2.3%	2.8%	12.5%	25.2%	57.3%	
586	Overall rating of psychiatric techs	1.9%	3.1%	11.6%	28.0%	55.5%	
2,363	**Program Activities**	3.1%	5.5%	17.1%	32.6%	41.7%	
593	Helpfulness of contact with staff	2.9%	4.7%	16.2%	34.7%	41.5%	
591	Time in therapeutic activities	3.2%	7.4%	19.3%	32.8%	37.2%	
590	Helpfulness group therapy	3.2%	4.7%	17.3%	31.0%	43.7%	
589	Helpfulness social/rec activities	3.2%	5.1%	15.6%	31.7%	44.3%	
1,631	**Visitors & Family**	4.1%	5.0%	16.7%	27.7%	46.4%	
410	Staff's courtesy toward visitors	2.4%	2.9%	15.6%	29.5%	49.5%	
414	Adequacy of visiting hours	8.2%	9.7%	19.6%	24.9%	37.7%	

Continued...

INPATIENT BEHAV. HEALTH REPORT

Frequency Analysis

n	Overall Section / Question	Very Poor %	Poor %	Fair %	Good %	Very Good %	Distribution
405	Confidentiality re visitors	2.5%	3.5%	17.3%	26.9%	49.9%	
402	Space to meet with family/friends	3.2%	4.0%	14.4%	29.6%	48.8%	
2,329	**Discharge**	3.2%	3.1%	9.7%	28.1%	55.9%	
597	Felt prepared for discharge	3.5%	3.9%	9.2%	26.3%	57.1%	
576	Understand disch med instructions	2.6%	2.3%	10.2%	29.2%	55.7%	
579	Info re care after discharge	3.1%	2.9%	9.7%	28.5%	55.8%	
577	Discharge instructions if need help	3.6%	3.3%	9.5%	28.6%	54.9%	
5,594	**Personal Issues**	4.1%	3.9%	15.0%	29.9%	47.1%	
574	Staff concern for privacy	2.6%	3.5%	14.3%	31.5%	48.1%	
571	Staff asked about physical pain	5.1%	3.9%	13.5%	32.6%	45.0%	
522	Physical pain taken care of	6.5%	5.9%	15.1%	28.0%	44.4%	
569	Safety felt on unit	2.3%	3.3%	14.8%	30.9%	48.7%	
547	Sensitive to lang/cultural needs	1.8%	1.8%	13.5%	30.5%	52.3%	
568	Sensitive to emotional needs	3.5%	3.0%	14.8%	29.8%	48.9%	
542	Sensitive to spiritual needs	3.7%	3.9%	15.9%	29.2%	47.4%	
567	Included in decisions re care	6.0%	5.8%	16.0%	30.9%	41.3%	
572	Staff concern to treat with respect †	3.7%	2.8%	14.3%	27.4%	51.7%	
562	Response to concerns/complaints †	5.9%	5.3%	17.6%	28.5%	42.7%	
4,565	**Overall Assessment**	4.0%	4.7%	15.5%	29.4%	46.3%	
574	Overall impression of the hospital	4.7%	6.6%	19.2%	33.3%	36.2%	
570	Feel condition has improved	2.5%	3.3%	13.5%	32.1%	48.6%	
574	Staff worked together care for you	3.1%	3.5%	15.3%	30.8%	47.2%	
573	Overall rating of care given	4.2%	4.7%	17.3%	30.4%	43.5%	
563	Likelihood of recommending	10.5%	7.1%	15.5%	24.0%	43.0%	
571	Overall cleanliness of hospital †	3.2%	4.9%	16.3%	29.2%	46.4%	
571	Kindness of staff †	1.8%	3.7%	14.2%	28.2%	52.2%	
569	Hopefulness as result of care †	2.5%	3.7%	12.8%	27.4%	53.6%	
560	**Medical Doctor**	6.3%	4.8%	17.3%	27.3%	44.3%	
560	Overall rating of medical doctor †	6.3%	4.8%	17.3%	27.3%	44.3%	

Joint Commission:

Introduction to Leadership Structure, Standards LD.01.01.01 Through LD.01.05.01
Each hospital, regardless of its complexity, has a structured leadership. The leadership structure may consist of distinct groups, or leaders may act as a whole. Individual leaders may participate in more than one group and may have several different roles. A leadership group is composed of individuals in senior positions with clearly defined, unique responsibilities. These groups might include governance, management, and medical staff and clinical staff. Not every hospital will have all of these groups, and an individual may be a member of more than one group.

Many leadership responsibilities directly affect the provision of care, treatment, and services, as well as the day-to-day operations of the hospital. In some cases, these responsibilities will be shared among leadership groups, and in other cases, a particular leader or leadership group has primary responsibility. Regardless of the hospital's structure, it is important that leaders carry out all their responsibilities.

A variety of individuals may work in the hospital, including licensed independent practitioners, staff, volunteers, students, and independent contractors. These standards describe the overall responsibility of the governing body for the safety and quality of care, treatment, and services provided by all of these individuals. In hospitals, the organized medical staff is responsible for overseeing the quality of care provided by individuals with privileges. The structure of the organized medical staff and its responsibilities are covered in the "Medical Staff" (MS) chapter.

How well leaders work together is key to effective hospital performance, and the standards emphasize this. Leaders from different groups—governance, senior management, and the organized medical staff—bring different skills, experiences, and perspectives to the hospital. Working together means that leaders from all groups have the opportunity to participate in discussions and have their opinions heard. Depending on the topic and the hospital, individuals from different leadership groups may participate in decision making, and the governing body may delegate decision making to certain leadership groups. Final decisions, however, are always the ultimate responsibility of the governing body; this key principle is assumed in any standard that describes how leaders work together.

The chief executive provides for the following:
- Information and support systems
- Physical and financial assets

The chief executive identifies a nurse leader at the executive level who participates in decision making. (See also NR.01.01.01, EP 3 for specific nurse leader responsibilities)

CMS:

§482.12(b) Standard: Chief Executive Officer
The governing body must appoint a chief executive officer who is responsible for managing the hospital.

Interpretive Guidelines §482.12(b)
The Governing Body must appoint one chief executive officer who is responsible for managing the entire hospital.

Survey Procedures §482.12(b)
- Verify that the hospital has only one chief executive officer for the entire hospital.
- Verify that the governing body has appointed the chief executive officer.
- Verify that the chief executive officer is responsible for managing the entire hospital.

AHCA – FL State Regulations

59A-3.273 Management and Administration.

(1) Each hospital shall be under the direction of a chief executive officer appointed by the governing body, who is responsible for the operation of the hospital in a manner commensurate with the authority conferred by the governing body.

(2) The chief executive officer shall take all reasonable steps to provide for:

(a) Compliance with applicable laws and regulations; and

(b) The review of and prompt action on reports and recommendations of authorized planning, regulatory, and inspecting agencies.

(3) The chief executive officer shall provide for the following:

(a) Establishment and implementation of organized management and administrative functions, including:

1. Clear lines of responsibility and accountability within and between department heads and administrative staff;

2. Effective communication mechanisms among departments, medical staff, the administration and the governing body;

3. Internal controls;

4. Coordination of services with the identified needs of the patient population;

5. A policy on patient rights and responsibilities;

6. A mechanism for receiving and responding to complaints concerning patient care;

7. A policy on withholding resuscitative services;

8. Policies and procedures on identification and referral of organ and tissue donors including notification of organ and tissue procurement agencies when organs and tissues become available as specified under Rule 59A-3.219, F.A.C.;

9. Policies and procedures for meeting the communication needs of multicultural populations and persons with impaired hearing or speaking skills;

10. Policies and procedures on discharge planning;

11. A policy to assist in accessing educational services for children or adolescents when treatment requires a significant absence from school;

12. Policies and procedures to assure that the treatment, education and developmental needs of neonates, children and adolescents transferred from one setting to another are assessed;

13. Dissemination and enforcement of a policy prohibiting the use of smoking materials in hospital buildings and procedures for exceptions authorized for patients by a physician's written authorization;

14. A policy regarding the use of restraints and seclusion; and

15. A comprehensive emergency management plan which meets the requirements of paragraph 395.1055(1)(c), F.S., and Rule 59A-3.078, F.A.C.

(b) Personnel policies and practices which address:

1. Non-discriminatory employment practices;

2. Verification of credentials including current licensure and certification;

3. Periodic performance evaluations; and

4. Provision of employee health services.

(c) Financial policies and procedures;

(d) An internal risk management program which meets the requirements of Section 395.0197, F.S., and Chapter 59A-10, F.S.C., and

(e) Assurance of compliance with educational requirements on human immunodeficiency virus and acquired immune deficiency syndrome pursuant to Sections 381.0034 and 381.0035, F.S., and Chapter 64D-2, F.A.C., September 1994.

Specific Authority 395.1055 FS. Law Implemented 395.0197, 395.1055 FS. History–New 9-4-95, Formerly 59A-3.218.